EDMUND G. BROWN JR., Attorney General
of the State of California
FRANK H. PACOE
Supervising Deputy Attorney General
LESLIE E. BRAST, State Bar No. 203296
Deputy Attorney General
California Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5548
Facsimile: (415) 703-5480

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHELLE SWANSON** 2241 Jackson Street, Apt. 1 San Francisco, CA 94115 Registered Nurse License No. 579436 Respondent.	Case No. 2008-120 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant), brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about April 4, 2001, the Board of Registered Nursing (Board) issued Registered Nurse License Number 579436 to Michelle Swanson (Respondent). The license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2008, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

STATUTORY PROVISIONS

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.

. . .

(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof. . ."

6. Code section 2762 states:

"*In addition to other acts constituting unprofessional conduct within the meaning* of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

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(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.

. . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

7. Health and Safety Code section 11173, subdivision (a), provides that "[no] person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact."

8. Code section 4060 provides, in pertinent part:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, [or] a physician assistant pursuant to Section 3502.1 . . ."

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REGULATORY PROVISIONS

9. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

10. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

11. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

12. California Code of Regulations, title 16, section 1444, provides in pertinent part that "[a] conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare."

CONTROLLED SUBSTANCES / DANGEROUS DRUGS

13. Code section 4021 states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

14. Code section 4022 provides:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only' or words of similar import.

(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import . . .

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

15. **Fentanyl Citrate** is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug within the

meaning of Code section 4022. Fentanyl and fentanyl citrate preparations are strong analgesics, pharmacodynamically similar to meperidine and morphine. They are used pre-operatively, during surgery and in the immediate post-operative period, as well as for the management of breakthrough cancer pain.

16. **Lorazepam** is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug within the meaning of Code section 4022. Lorazepam, also known by the brand name **Ativan**, is a benzodiazepine, used for the management of anxiety disorders, seizure conditions and for purposes of pre-operative sedation and anxiety relief.

17. **Midazolam** is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(21), and a dangerous drug within the meaning of Code section 4022. Midazolam, also known by the brand name **Versed**, is a benzodiazepine, used for pre-operative sedation, particularly when anxiety relief and diminished recall are desired.

18. **Morphine Sulfate** is a phenanthrene-derivative agonist and the principal alkaloid of opium. It is a powerful analgesic used to relieve severe, acute pain or moderate to severe chronic pain. It is also used for pre-operative sedation or as a supplement to anesthesia. As a single entity, morphine sulfate is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug within the meaning of Code section 4022.

19. **Oxycodone HCL/Acetaminophen** is a compound consisting of acetaminophen and oxycodone, also known by the brand names **Tylox**, **Roxicet**, **Percocet** and **Endocet**. Oxycodone is a strong opioid analgesic used in the management of moderate to moderately severe pain, often administered in combination with acetaminophen or aspirin. Acetaminophen is a synthetic non-opioid analgesic used extensively in the treatment of mild to moderate pain and fever. Oxycodone preparations are subject to control as Schedule II controlled substances as designated by Health and Safety Code section 11055, subdivision (b)(1)(N), and are dangerous drugs within the meaning of Code section 4022.

20. **Tylenol with Codeine** is an analgesic compound used for the relief of mild to moderate pain. Tylenol is a brand name for **acetaminophen**, a synthetic non-opioid analgesic used extensively in the treatment of mild to moderate pain and fever. Codeine is a mild opioid analgesic used for relief of mild to moderate pain, often administered in combination with acetaminophen or aspirin. Acetaminophen and codeine together produce a greater analgesic effect than either used alone. Codeine preparations, including **Tylenol with Codeine No. 3**, are subject to control as Schedule II controlled substances as designated by Health and Safety Code section 11055, subdivision (b)(1)(H), and are dangerous drugs within the meaning of Code section 4022.

21. **Vicodin** is a brand name for an analgesic compound consisting of **hydrocodone bitartrate** and **acetaminophen**. Hydrocodone bitartrate is a mild opioid analgesic similar to codeine used for the relief of moderate to moderately severe pain. It should be given as infrequently as possible in the smallest effective dose to minimize the development of tolerance and physical dependence. Acetaminophen is a synthetic non-opioid analgesic used extensively in the treatment of mild to moderate pain and fever. Vicodin is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug within the meaning of Code section 4022.

COST RECOVERY

22. Code section 125.3 provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable investigation and enforcement costs of the case.

FACTUAL BACKGROUND

23. During June through October 2005, Respondent worked as a registered nurse at the Women's Options clinic of San Francisco General Hospital (Clinic). The clinic provides women's reproductive health services, including abortion, family planning, and counseling. During an abortion clinic on or about October 14, 2005, Respondent appeared dazed and disoriented, as follows:

a. Respondent was seen standing in blood-stained scrubs with a bloody syringe in her hand. When questioned by a co-worker, she was unable to say what she was holding or whose blood stained her scrubs.

b. Respondent was seen exiting the bathroom holding part of an IV. She stated she had to check on a patient, but entered the medication room instead.

c. Respondent was seen "wasting meds" at the Clinic's SureMed[1] machine, then shut her eyes and looked like she was going to faint before being taken to the Emergency Room by her nurse manager.

d. Respondent left the Emergency Room before being seen.

24. An audit of Respondent's SureMed withdrawals, wastes and returns between about June 29 and October 13, 2005 could not be reconciled with corresponding patient medical records and revealed numerous medication discrepancies as follows:

San Francisco General Hospital / Women's Options Clinic (June - October 2005)

Patient 1[2]

On or about July 18, 2005, Patient 1 was seen at the Clinic for a blood draw appointment only; no medications were ordered.

a. On or about July 18, 2005, at approximately 8:48 AM, Respondent obtained from the Clinic's SureMed two 2 mg/2 ml vials of Midazolam without a physician's order and did not document or otherwise properly account for the medication.

b. On or about July 18, 2005, at approximately 8:49 AM, Respondent obtained from the Clinic's SureMed two injectables of Fentanyl 100 mcg/2 ml without a physician's order and did not document or otherwise properly account for the medication.

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1. SureMed is a brand name for an automated medication dispensing and supply system. A Personal Identification Number (PIN) code is used to access controlled substances from the system which automatically logs all transactions involving the removal of controlled substances, including the names of the person accessing the system and the patient for whom the substances were ordered, the date, time, and dosage being obtained.

2. Patients are identified numerically herein to protect their confidentiality.

Patient 2

a. On or about October 13, 2005, at approximately 11:55 AM, Patient 2's physician ordered "Midazolam, 2 mg (2 cc) IV x1 PRN mod anxiety." On or about October 14, 2005 at approximately 9:23 AM, Respondent obtained from the Clinic's SureMed three vials of Midazolam 2 mg/2 ml and charted administration of 2 mg Versed at approximately 10:20 AM, 1 mg Versed at approximately 10:30 AM, and 1 mg Versed at approximately 10:34 AM, but did not document or otherwise properly account for the remaining 2 mg (1 vial) Midazolam.

b. On or about October 13, 2005, at approximately 11:55 AM, Patient 2's physician ordered "Lorazepam (Ativan) 1 mg SL x 1 PRN anxiety" and "Ativan 2 mg SL." On or about October 14, 2005, at approximately 9:23 AM, Respondent obtained from the Clinic's SureMed three tablets Lorazepam 1 mg; at approximately 9:25 AM, she wasted 3 tablets Lorazepam, witnessed by Rachelle Goering, RN. However, Nurse Goering did not work on October 14, 2005 and did not witness the waste.

c. On or about October 14, 2005, at approximately 9:23 AM, Respondent obtained from the Clinic's SureMed one tablet Lorazepam 1 mg; at approximately 9:28 AM, she wasted one tablet Lorazepam 1 mg, witnessed by Rachelle Goering. However, Nurse Goering did not work on October 14, 2005 and did not witness the waste.

d. On or about October 13, 2005, at approximately 11:55 AM, Patient 2's physician ordered "Fentanyl 100 mcg (2 cc) IV x 1 PRN severe pain." On or about October 14, 2005, at approximately 9:23 AM, Respondent obtained from the Clinic's SureMed three Fentanyl 100 mcg/2 ml injectables. At approximately 9:27 AM, Respondent returned two Fentanyl injectables. However, on or about October 14, 2005, Respondent charted administration of 100 mcg Fentanyl at approximately 10:20 AM, 50 mcg Fentanyl at approximately 10:30 AM, and 50 mcg Fentanyl at approximately 10:34 AM for a total of 200 mcg Fentanyl. Her charting cannot be reconciled with the amounts removed and returned.

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e. On or about October 14, 2005, Respondent accessed SureMed to obtain one tablet Lorazepam, but did not complete the transaction. Again, at approximately 9:24 AM the same day, Respondent attempted removal of one tablet Lorazepam, but did not complete the transaction.

f. On or about October 14, 2004, at approximately 10:15 AM, Respondent obtained from the Clinic's SureMed two Fentanyl 100 mcg/2 ml injectables. At approximately 10:16 AM, Respondent wasted 200 mcg Fentanyl, witnessed by Rachelle Goering, RN. However, Nurse Goering did not work that day and did not witness the waste.

g. On or about October 14, 2005, at approximately 11:58 AM, Respondent accessed SureMed and wasted 1 mg Midazolam 2 mg/2 ml, witnessed by Sarah Mann, RN. Nurse Mann, however, did not witness the waste.

h. On or about October 14, 2005, at approximately 11:58 AM, Respondent accessed SureMed and wasted 50 mcg Fentanyl 100 mcg/2 ml, witnessed by Sarah Mann, RN. Nurse Mann, however, did not witness the waste.

Patient 3

a. On or about September 15, 2005, at approximately 10:00 AM, Patient 3's physician ordered "Fentanyl 100 mcg (2 cc) IV x 1 PRN severe pain." On or about September 16, 2005, at approximately 8:33 AM, Respondent obtained from the Clinic's SureMed two Fentanyl 100 mcg/2 ml injectables, but did not document or otherwise properly account for the two Fentanyl injectables.

b. On or about September 15, 2005, Patient 3's physician ordered "Morphine 4 mg IV or IM q 30 minutes PRN severe pain." On or about September 16, 2005, at approximately 11:14 AM, Respondent obtained from the Clinic's SureMed one Morphine Sulfate 4 mg syringe; at approximately 11:15 AM, she wasted 2 mg Morphine Sulfate, witnessed by Rachelle Goering, RN. However, Nurse Goering did not work that day and did not witness the waste.

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Patient 4

a. On or about October 6, 2005, at approximately 5:00 PM, Patient 4's physician ordered "Morphine 4 mg IV or IM q 30 minutes PRN severe pain." On or about October 7, 2005, at approximately 11:36 AM, Respondent obtained from the Clinic's SureMed one 4 mg syringe of Morphine Sulfate; she wasted 2 mg Morphine Sulfate at approximately 11:37 AM, witnessed by Rachelle Goering, RN. Respondent did not document or otherwise properly account for 2 mg Morphine Sulfate.

b. On or about October 6, 2005, Patient 4's physician ordered "Fentanyl 100 mcg (2 cc) IV x 1 PRN severe pain." On or about October 7, 2005, at approximately 11:38 AM, Respondent obtained from the Clinic's SureMed Fentanyl 100 mcg/2 ml; at approximately 11:38 AM, she wasted 100 mcg Fentanyl, witnessed by Rachelle Goering RN. However, Respondent charted administration of 100 mcg Fentanyl at approximately 9:04 AM, 50 mcg Fentanyl at approximately 9:58 AM, 50 mcg Fentanyl at approximately 10:06 AM, 50 mcg Fentanyl at approximately 10:09 AM, and 50 mcg Fentanyl at approximately 10:16 AM, for a total of 300 mcg Fentanyl for which there was no corresponding withdrawal.

c. On or about October 6, 2005, Patient 4's physician ordered "Midazolam 2 mg (2 cc) IV x 1 PRN mod anxiety." On or about October 7, 2005, at approximately 11:38 AM, Respondent obtained from the Clinic's SureMed Midazolam 2 mg/ 2 ml vial, but did not document or otherwise properly account for the medication.

Patient 5

a. On or about August 19, 2005, at approximately 11:00 AM, Patient 5's physician ordered "Ativan 1 mg." On or about August 19, 2005, at approximately 10:25 AM, Respondent obtained from the Clinic's SureMed one tablet Lorazepam 1 mg and charted administration of 1 mg Ativan at approximately 9:48 AM, more than 30 minutes before SureMed recorded Respondent's removal of the medication.

b. On or about August 18, 2005, at approximately 11:00 AM, Patient 5's physician ordered "Fentanyl 100 mcg (2 cc) IV x 1 PRN severe pain." On or about August 19, 2005, at approximately 10:25 AM, Respondent obtained from the Clinic's SureMed

Fentanyl 100 mcg/2 ml; she charted, however, administration of 100 mcg Fentanyl at approximately 9:47 AM, 50 mcg Fentanyl at approximately 9:58 AM, 50 mcg Fentanyl at approximately 9:49 AM, 50 mcg Fentanyl at approximately 10:07 AM, and 50 mcg Fentanyl at approximately 10:09 AM, for a total of 300 mcg Fentanyl. There is no documentation indicating Respondent withdrew more than 100 mcg Fentanyl from SureMed, nor is there documentation showing from where Respondent obtained the additional 200 mcg Fentanyl she charted as administered to Patient 5.

c. On or about August 18, 2005, at approximately 11:00 AM, Patient 5's physician ordered "Midazolam 2 mg (2 cc) IV x 1 PRN mod anxiety." Respondent did not withdraw this medication from SureMed; however, she charted administration of Versed 2 mg at approximately 9:47 AM, Versed 1 mg IVP at approximately 10:02 AM, Versed 1 mg IVP at approximately 9:49 AM, Versed 1 mg IVP at approximately 10:07 AM, and Versed 1 mg IVP at approximately 10:09 AM.

Patient 6

a. On or about August 9, 2005, at approximately 3:00 PM, Patient 6's physician ordered "Midazolam 2 mg (2 cc) IV x 1 PRN mod anxiety." On or about August 19, 2005, at approximately 8:44 AM, Respondent obtained from the Clinic's SureMed one vial Midazolam 2 mg/2 ml and charted administration of Versed 2 mg at approximately 10:44 AM. Respondent also charted administration of Versed 1 mg IVP at approximately 10:46 AM and Versed 1 mg IVP at approximately 10:50 AM. There was no corresponding SureMed withdrawal for Patient 6.

b. On or about August 19, 2005, at approximately 9:40 AM, Respondent obtained from the Clinic's SureMed one tablet Lorazepam 1 mg without a physician's order and did not document or otherwise properly account for the medication.

Patient 7

a. On or about July 8, 2005, at approximately 12:01 PM, Respondent charted administration of Fentanyl 50 mcg IVP; there was no corresponding SureMed withdrawal for the medication.

Patient 8

Following her procedure on or about August 24, 2005, Patient 8 was discharged at approximately 1:30 PM.

a. On or about August 24, 2005, at approximately 11:50 AM, Patient 8's physician ordered "Midazolam 2 mg (2cc) IV x 1 PRN mod anxiety." On or about August 24, 2005, at approximately 9:36 AM, Respondent obtained from the Clinic's SureMed Midazolam 2 mg/2 ml. She charted administration of Versed 1 mg at approximately 12:03 PM and Versed 1 mg IVP at approximately 12:06 PM; she also charted administration of Versed 1 mg at approximately 12:13 PM and Versed 1 mg at approximately 12:19 PM, for which there were no corresponding SureMed withdrawals.

b. On or about August 24, 2005, at approximately 11:50 AM, Patient 8's physician ordered "Fentanyl 100 mcg (2 cc) IV x 1 PRN severe pain." On or about August 24, 2005, at approximately 9:36 AM, Respondent obtained from the Clinic's SureMed 100 mcg Fentanyl and charted administration of 100 mcg Fentanyl at approximately 12:02 PM. Respondent also charted administration of Fentanyl 50 mcg at approximately 12:06 PM, Fentanyl 50 mcg at approximately 12:10 PM, and Fentanyl 50 mcg at approximately 12:13 PM for which there were no corresponding SureMed withdrawals.

c. On or about August 24, 2005, at approximately 10:40 AM, Respondent obtained from the Clinic's SureMed, without a physician's order, 1 mg Lorazepam; she did not document or otherwise properly account for the medication.

d. On or about August 24, 2005, at approximately 11:50 AM, Patient 8's physician ordered post-operative "Acetaminophen 500 mg/Hydrocodone 5 mg (Vicodin) 1-2 tabs PO x 1 PRN mod pain." On or about August 24, 2005, at approximately 10:40 AM, Respondent obtained from the Clinic's SureMed one tablet Vicodin/Acetaminophen but did not document or otherwise properly account for the medication.

e. On or about August 24, 2005, at approximately 1:40 PM, approximately 10 minutes after Patient 8 was discharged, Respondent obtained from the Clinic's SureMed two Fentanyl 100 mcg/2 ml injectables . Respondent did not document or otherwise

properly account for the medication.

Patient 9

a. On or about October 13, 2005, at an unknown time, Patient 9's physician ordered "Morphine 4 mg IV or IM q 30 minutes PRN severe pain." On or about October 14, 2005, at approximately 11:52 AM, Respondent obtained from the Clinic's SureMed one 4 mg Morphine Sulfate syringe. At approximately 11:52 AM, she wasted 2 mg, witnessed by Rachelle Goering, RN. However, Nurse Goering did not work that day and did not witness the waste. Respondent did not document or otherwise properly account for the remaining 2 mg Morphine Sulfate.

Patient 10

a. On or about September 15, 2005, at approximately 10:00 AM, Patient 10's physician ordered "Midazolam 2 mg (2 cc) IV x 1 PRN mod anxiety." On or about September 16, 2005, at approximately 8:29 AM, Respondent obtained from the Clinic's SureMed three vials of Midazolam HCL 2 mg/2 ml, but did not document or otherwise properly account for the medication.

b. On or about September 15, 2005, at approximately 10:00 AM, Patient 10's physician ordered "Fentanyl 100 mcg (2 cc) IV x 1 PRN severe pain." On or about September 16, 2005, at approximately 8:29 AM, Respondent obtained from the Clinic's SureMed three injectables of Fentanyl 100 mcg/2 ml, but did not document or otherwise properly account for the medication.

c. On or about September 15, 2005, at approximately 10:00 AM, Patient 10's physician ordered "Acetaminophen 500 mg/Hydrocodone 5 mg (Vicodin) 1-2 tabs PO x 1 PRN mod pain." On or about September 16, 2005, at approximately 11:23 AM, Respondent obtained from the Clinic's SureMed two tablets Vicodin. At approximately 11:53 AM, Respondent returned one tablet and wasted one tablet, witnessed by Rachelle Goering, RN. However, Nurse Goering did not work that day and did not witness the waste.

d. On or about September 15, 2005, at approximately 10:00 AM, Patient 10's physician ordered "Morphine 4 mg IV or IM q 30 minutes PRN severe pain." On or

about September 16, 2006, at approximately 11:52 AM, Respondent obtained from the Clinic's SureMed one 4 mg Morphine Sulfate syringe, and wasted 2 mg, witnessed by Rachelle Goering, RN. However, Nurse Goering did not work that day and did not witness the waste.

Patient 12

On or about August 19, 2005, Patient 12 was seen for a blood draw appointment only; no medications were ordered.

a. On or about August 19, 2005, at approximately 9:33 AM, Respondent obtained from the Clinic's SureMed one vial Midazolam HCL 2 mg/2 ml, without a physician's order; at approximately 1:17 PM, Respondent wasted the medication without a witness.

b. On or about August 19, 2005, at approximately 9:34 AM, Respondent obtained from the Clinic's SureMed one injectable Fentanyl 100 mcg/2 ml, without a physician's order. At approximately 1:18 PM, Respondent returned the medication.

c. On or about August 19, 2005, at approximately 1:17 PM, Respondent returned one vial Midazolam HCL 2 mg/2 ml; however, there is no corresponding withdrawal for the medication.

Patient 13

Following her procedure on or about September 14, 2005, Patient 13 was discharged at approximately 4:44 PM.

a. On or about September 13, 2005, at approximately 2:00 PM, Patient 13's physician ordered "Acetaminophen 300 mg/Codeine 30 mg (Tyco #3) 1-2 tabs PO x 1 PRN mod pain." On or about September 14, 2005, at approximately 3:19 PM, Respondent obtained from the Clinic's SureMed two tablets Tylenol with Codeine No. 3 and charted administration of one tablet at 3:15 PM. She did not document or otherwise properly account for the remaining tablet.

b. On or about September 13, 2005, at approximately 2:00 PM, Patient 13's physician ordered "Morphine 4 mg IV or IM q 30 minutes PRN severe pain." On or about September 14, 2005, at approximately 5:32 PM, Respondent obtained from the Clinic's

SureMed one 4 mg Morphine Sulfate syringe and wasted 2 mg, witnessed by Rachelle Goering, RN. Respondent did not document or otherwise properly account for the remaining medication.

Patient 15

Following her procedure on or about September 30, 2005, Patient 15 was discharged at approximately 1:30 PM.

a. On or about September 30, 2005, at an unknown time, Patient 15's physician ordered "Midazolam 2 mg (2 cc) IV x 1 PRN mod anxiety." At approximately 2:43 PM that day, more than an hour after Patient 15 was discharged, Respondent obtained from the Clinic's SureMed two vials Midazolam HCL 2 mg/2 ml; she did not document or otherwise properly account for the medication.

b. On or about September 30, 2005, at an unknown time, Patient 15's physician ordered "Fentanyl 100 mcg (2 cc) IV x 1 PRN severe pain." At approximately 2:43 PM that day, more than an hour after Patient 15 was discharged, Respondent obtained from the Clinic's SureMed two Fentanyl 100 mcg injectables; she did not document or otherwise properly account for the medication.

c. On or about September 30, 2005, at approximately 5:57 PM, Respondent returned one vial Midazolam HCL 2 mg/2 ml; there was no corresponding medication withdrawal.

d. On or about September 30, 2005, at approximately 5:57 PM, Respondent wasted 50 mcg Fentanyl 100 mcg, witnessed by Rachelle Goering, RN. There is no corresponding medication withdrawal and Nurse Goering did not work that day and did not witness the waste.

e. On or about September 30, 2005, at approximately 6:15 PM, Respondent wasted one vial Midazolam HCL 2 mg/2 ml, witnessed by Rachelle Goering, RN. There was no corresponding medication withdrawal and Nurse Goering did not work that day and did not witness the waste.

f. On or about September 30, 2005, at approximately 6:15 PM, Respondent returned one vial Midazolam HCL 2 mg/2 ml; there was no corresponding

medication withdrawal.

g. On or about September 30, 2005, at approximately 6:21 PM, Respondent wasted one vial Midazolam HCL 2 mg/2 ml, witnessed by Rachelle Goering, RN. There was no corresponding medication withdrawal and Nurse Goering did not work that day and did not witness the waste.

h. On or about September 30, 2005, at approximately 6:21 PM, Respondent returned one vial Midazolam HCL 2 mg/2 ml; there was no corresponding medication withdrawal.

Patient 16

Following her procedure on or about September 30, 2005, Patient 16 was discharged at approximately 4:15 PM. Respondent did not sign or initial any nurse notes or medication administration records for Patient 16.

a. On or about September 29, 2005, at approximately 2:30 PM, Patient 16's physician ordered "Midazolam 2 mg (2 cc) IV x 1 PRN mod anxiety." On or about September 30, 2005, at approximately 10:58 AM, Respondent obtained from the Clinic's SureMed two vials of Midazolam HCL 2 mg/2 ml; she did not document or otherwise properly account for the medication.

b. On or about September 29, 2005, at approximately 2:30 PM, Patient 16's physician ordered "Fentanyl 100 mcg (2cc) IV x 1 PRN severe pain." On or about September 30, 2005, at approximately 10:58 AM, Respondent obtained from the Clinic's SureMed two Fentanyl 100 mcg syringes; she did not document or otherwise properly account for the medication.

c. On or about September 30, 2005, at 6:02 PM, nearly two hours after Patient 16's discharge, Respondent obtained from the Clinic's SureMed one vial Midazolam HCL 2 mg/2 ml. She did not document or otherwise properly account for the medication.

d. On or about September 30, 2005, at 6:02 PM, nearly two hours after Patient 16's discharge, Respondent obtained from the Clinic's SureMed one Fentanyl 100 mcg/2 ml injectable. She did not document or otherwise properly account for the medication.

e. On or about September 30, 2005, at 6:02 PM, Respondent wasted 1 mg Midazolam HCL 2 mg/2 ml, witnessed by Rachelle Goering, RN. Nurse Goering did not work that day and did not witness the waste.

f. On or about September 30, 2005, at 6:02 PM, Respondent wasted 50 mcg of an 100 mcg Fentanyl injectable, witnessed by Rachelle Goering, RN. Nurse Goering did not work that day and did not witness the waste.

g. On or about September 29, 2005, at approximately 2:30 PM, Patient 16's physician ordered "Morphine 4 mg IV or IM q 30 minutes PRN severe pain." On or about September 30, 2005, at approximately 6:16 PM, Respondent obtained from the Clinic's SureMed one 4 mg Morphine Sulfate syringe and wasted 2 mg, witnessed by Rachelle Goering, RN. Respondent did not document or otherwise properly account for the remaining 2 mg and Nurse Goering did not work that day and did not witness the waste.

h. On September 30, 2005, at approximately 6:21 PM, Respondent wasted one vial Midazolam HCL 2 mg/2 ml, witnessed by Rachelle Goering, RN. There was no corresponding medication withdrawal and Nurse Goering did not work that day and did not witness the waste.

i. On or about September 20, 2005, at approximately 6:21 PM, Respondent returned one vial Midazolam HCL 2 mg/2 ml; there is no corresponding withdrawal for the medication.

Patient 17

Respondent did not sign or initial any nurse notes or medication administration records for Patient 17.

a. On or about September 6, 2005, at approximately 12:00 PM, Patient 17's physician ordered "Morphine 4 mg IV or IM q 30 minutes PRN severe pain." On or about September 7, 2005, at approximately 3:25 PM, Respondent obtained from the Clinic's SureMed one 4 mg Morphine Sulfate syringe; she did not document or otherwise properly account for the medication.

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Patient 18

Following her procedure on or about October 3, 2005, Patient 18 was discharged at approximately 12:05 PM.

a. On or about October 3, 2005, at approximately 10:30 AM, Patient 18's physician ordered "Fentanyl 100 mcg (2 cc) IV x 1 PRN severe pain." On or about October 3, 2005, at approximately 10:20 AM, Respondent obtained from the Clinic's SureMed two Fentanyl 100 mcg injectables. At approximately 10:37 AM, she charted administration of 100 mcg Fentanyl, but did not document or otherwise properly account for the remaining 100 mcg Fentanyl. At approximately 10:20 AM the same day, Respondent wasted 300 mcg Fentanyl, witnessed by Rachelle Goering, RN. However, Nurse Goering did not work that day and did not witness the waste.

b. On or about October 3, 2005, at approximately 10:30 AM, Patient 18's physician ordered "Acetaminophen 500 mg/Hydrocodone 5 mg (Vicodin) 1-2 tabs PO x 1 PRN mod pain." At approximately 12:15 PM the same day, after Patient 18's discharge, Respondent obtained from the Clinic's SureMed one Vicodin tablet, wasted one tablet, witnessed by Rachelle Goering, RN, and returned one tablet for which there is no corresponding withdrawal. Respondent did not document or otherwise properly account for the medication, and Nurse Goering did not work that day and did not witness the waste.

c. On or about October 3, 2005, at approximately 10:30 AM, Patient 18's physician ordered "Midazolam 2 mg (2 cc) IV x 1 PRN mod anxiety." At approximately 2:17 PM the same day, more than 2 hours after Patient 18's discharge, Respondent wasted one vial Midazolam, witnessed by Monica McLemore, RN, and returned one vial. There was no corresponding withdrawal of the medication.

d. On or about October 3, 2005, at approximately 2:17 PM, more than 2 hours after Patient 18's discharge, Respondent returned one Fentanyl injectable for which there was no corresponding withdrawal.

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Patient 19

Following her procedure on or about September 29, 2005, Patient 19 was discharged at approximately 11:25 AM.

a. On or about September 29, 2005, at approximately 1:20 PM, Patient 19's physician ordered "Midazolam 2 mg (2 cc) IV x 1 PRN mod anxiety." At approximately 5:55 PM the same day, more than four hours after Patient 19's discharge, Respondent obtained from the Clinic's SureMed one vial Midazolam 2 mg/2 ml and wasted 1 mg at approximately 5:56 PM, witnessed by Rachelle Goering, RN. Respondent did not document or otherwise properly account for the remaining 1 mg, and Nurse Goering did not work that day and did not witness the waste.

b. On September 30, 2005, at approximately 5:55 PM, more than four hours after Patient 19's discharge, Respondent obtained from the Clinic's SureMed one Fentanyl 100 mcg/2 ml injectable, and wasted 50 mcg at approximately 5:56 PM, witnessed by Rachelle Goering, RN. Respondent did not document or otherwise properly account for the remaining 50 mcg, and Nurse Goering did not work that day and did not witness the waste.

25. On or about June 23, 2007, Respondent, dressed in scrubs and wearing a stethoscope and hand-written tag bearing the name "Maria Garcia," attempted to access secure medication cabinets at St. Mary's Medical Center in San Francisco, where she neither worked nor was authorized to be present. Respondent was detained by hospital security and subsequently arrested by San Francisco police. On or about June 28, 2007, in pending San Francisco Superior Court Case No. 2321838, Respondent pled not guilty to the following violations:

a. California Health and Safety Code section 11350, subdivision (a) (unauthorized possession of a controlled narcotic substance), a felony;

b. California Health and Safety Code section 11377, subdivision (a) (unauthorized possession of a controlled non-narcotic substance), a felony;

c. California Penal Code section 459 (burglary), a misdemeanor; and,

d. California Penal Code section 148.9 (false representation of identity to a peace officer), a misdemeanor.

26. On or about November 13, 2001, in Placer County Superior Court Case No. 72-1209, Respondent was convicted of having violated California Vehicle Code section 23103 / 23103.5 (reckless driving), a misdemeanor. Her conviction followed her September 2001 arrest for violations of California Vehicle Code section 23152, subdivisions (a) [driving under the influence of alcohol and/or drugs], and (b) [driving with a blood alcohol level of .08 percent or higher]. Respondent was placed on three years conditional probation, including completion of a 12-hour drug and alcohol education program.

FIRST CAUSE FOR DISCIPLINE

(Fraudulent Procurement of Controlled Substances)

27. Respondent is subject to disciplinary action for unprofessional conduct under Code sections 2762, subdivision (a), and 2761, subdivision (d), in that she obtained controlled substances by fraud, deceit, misrepresentation, subterfuge, or by the concealment of material facts, in violation of Health and Safety Code section 11173, subdivision (a), as described above in paragraphs 23 through 25.

SECOND CAUSE FOR DISCIPLINE

(False / Grossly Incorrect Medical Records)

28. Respondent is subject to disciplinary action for unprofessional conduct under Code sections 2762, subdivision (e), and 2761, subdivision (d), in that she made false, grossly incorrect, grossly inconsistent, or unintelligible entries in Clinic, patient, or other records pertaining to controlled substances, as described above in paragraph 24.

THIRD CAUSE FOR DISCIPLINE

(Wrongful Possession of Controlled Substances)

29. Respondent is subject to disciplinary action for unprofessional conduct under Code sections 2762, subdivision (a), and 2761, subdivision (d), in that she possessed controlled substances without a prescription in violation of Code section 4060, as described above in paragraphs 23 through 25.

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FOURTH CAUSE FOR DISCIPLINE

(Criminal Conviction)

30. Respondent is subject to disciplinary action under Code section 2761, subdivision (f), in that she was convicted of a crime substantially related to the qualifications, functions or duties of a registered nurse within the meaning of California Code of Regulations, title 16, section 1444. The circumstances are detailed above in paragraph 25.

FIFTH CAUSE FOR DISCIPLINE

(Wrongful Self-Administration of Controlled Substances)

31. Respondent is subject to disciplinary action for unprofessional conduct under Code sections 2762, subdivision (a), and 2761, subdivision (d), in that Respondent self-administered controlled substances, as described above in paragraphs 23 and 24.

SIXTH CAUSE FOR DISCIPLINE

(Dangerous or Injurious Use of Controlled Substances)

32. Respondent is subject to disciplinary action for unprofessional conduct under Code sections 2762, subdivision (b), and 2761, subdivision (d), in that she used controlled substances to such an extent or in such a manner as to be dangerous or injurious to herself, others, or the public, or to such an extent that such usage impaired Respondent's ability to safely practice nursing. The circumstances are detailed above in paragraphs 23 through 26.

SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

33. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2761, subdivision (a)(1), in that she committed acts of gross negligence within the meaning of California Code of Regulations, title 16, section 1442, as described above in paragraphs 23 through 25.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

34. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2761, subdivision (a), as described above in paragraphs 23 through 26.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 579436, issued to Michelle Swanson;

2. Ordering Michelle Swanson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 10/5/07

Elliot Hochberg for
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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